

90-DAY DISCHARGE PLAN REPORT

Michigan Department of Human Services

Directions: The 90-Day Discharge meeting must be held at least 90 days prior to a youth exiting care, in order to develop a discharge plan. The youth must be involved at every aspect of developing the plan. It must be personalized to the individual youth at his or her own discretion. Participants may include CASA workers, foster parents, biological parents, relatives, therapists, the youth's friends, teachers, employers, or anyone the youth considers to be a supportive contact and wishes to invite. A copy of the completed plan is to be given to the youth at the end of the meeting and the original must be kept in the case file.

Youth Information			
Last Name:	First Name	Middle Initial	Case Number:
Birth Date:	Age:	Gender	County of Jurisdiction:
			DHS Worker or Monitor Name:
			Worker Phone:
			Worker Email:
Address:			Tribal Worker Name:
City, Zip:			Worker Phone:
Phone:			Worker Email:
Email:			
Alternative Phone (cell, relative, etc.):			
Legal Status:			DHS Supervisor Name:
<input type="checkbox"/> Temporary Court Ward			Supervisor Phone:
<input type="checkbox"/> Permanent Court Ward			Supervisor Email:
<input type="checkbox"/> MCI Ward			
<input type="checkbox"/> Dual Ward			PAFC Worker Name:
<input type="checkbox"/> Young Adult Voluntary Foster Care			Worker Phone:
			Worker Email:
Is the youth remaining in care beyond his/her 18 th birthday?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			PAFC Supervisor Name:
Date/Time Held:			
Supervisor Phone:			
Site Location:			
Supervisor Email:			CMH Worker Name:
Names of those present and roles:			CMH Worker Phone:
			Worker Email:
			GAL Name:
			GAL Phone:
			GAL Email:
Date of Next Meeting (if applicable):			

Independent Living Skills	
1. What IL skills and services did the youth participate in? (check all that apply)	<u>Date Completed</u>
<input type="checkbox"/> Education	
<input type="checkbox"/> HS Graduation	
<input type="checkbox"/> GED Preparation	
<input type="checkbox"/> GED Testing	
<input type="checkbox"/> College Preparation	
<input type="checkbox"/> Career Testing	
<input type="checkbox"/> Employment/Training	

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- ☐ Daily Living
 - ☐ Meal Planning/Cooking
 - ☐ Buying Groceries
 - ☐ Can Do Own Laundry
 - ☐ Housekeeping
- ☐ Preventive Health Services
 - ☐ Personal Hygiene
 - ☐ Basic First Aid
- ☐ Parenting
- ☐ Budgeting/Financial Literacy
- ☐ Rental Responsibilities
- ☐ Housing Maintenance (minor repairs, exterior upkeep)
- ☐ Other (explain):

2. What additional IL skills and/or services does the youth need prior to discharge? (check all that apply)

- ☐ Education
- ☐ Employment/Training
- ☐ Daily Living
 - ☐ Meal Planning/Cooking
 - ☐ Buying Groceries
 - ☐ Can Do Own Laundry
 - ☐ Housekeeping
- ☐ Preventive Health Services
 - ☐ Personal Hygiene
 - ☐ Basic First Aid
- ☐ Parenting
- ☐ Budgeting/Financial Literacy
- ☐ Rental Responsibilities
- ☐ Housing Maintenance (minor repairs, exterior upkeep)
- ☐ Other (explain):

3. Who, and by what date, will be assisting the youth with these additional IL skills needed? (Please identify by name and title, and check all that apply)

- | <u>Name and Title</u> | <u>Deadline</u> |
|--|-----------------|
| <input type="checkbox"/> DHS Staff: | |
| <input type="checkbox"/> PAFC Staff: | |
| <input type="checkbox"/> Foster Parents: | |
| <input type="checkbox"/> Supportive Adult: | |
| <input type="checkbox"/> Mentor | |
| <input type="checkbox"/> MYOI Staff: | |
| <input type="checkbox"/> CASA: | |
| <input type="checkbox"/> Other (explain): | |

Housing

1. Upon transitioning out of care, what is the youth's plan for housing?

- ☐ Own Apartment
 - Has the lease been signed? ☐ Yes ☐ No
 - If yes, when was it signed?
 - If no, is there a date/time set up to sign the lease?
 - Has the security deposit been made? ☐ Yes ☐ No
 - Are YIT Funds being used? ☐ Yes ☐ No Application Date?
 - Has the first/last month's rent been paid? ☐ Yes ☐ No
 - Are YIT Funds being used? ☐ Yes ☐ No Application Date?

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- What is the plan to ensure ongoing rent is paid?

- ☐ College Dorm
- Has all required paperwork been submitted? ☐ Yes ☐ No
 - Is campus housing available year-round? ☐ Yes ☐ No
- ☐ Remain in current foster home
- ☐ SIL/IL
- ☐ Relative
- ☐ Legal Guardianship
- ☐ Biological Family
- ☐ Supportive Adult (name):
- Will the youth be provided with his/her own bedroom? ☐ Yes ☐ No
 - If no, where will he or she sleep?
- ☐ Friends
- Will the youth be provided with his/her own bedroom? ☐ Yes ☐ No
 - If no, where will he or she sleep?
- ☐ Adult Foster Care
- ☐ Military Housing
- ☐ Other (explain):

2. Is youth aware of emergency shelters in the area? ☐ Yes ☐ No

3. Who, and by what date, will assist the youth with these final tasks?

Name and Title

Deadline

- ☐ DHS Staff:
- ☐ PAFC Staff:
- ☐ Foster Parents:
- ☐ Housing Agency:
- ☐ MYOI Staff:
- ☐ CASA:
- ☐ Supportive Adult:
- ☐ Other (explain):

Education

1. Will the youth graduate from high school prior to transitioning out of foster care? ☐ Yes ☐ No
- If no, does the youth have a plan for completing high school or a GED? ☐ Yes ☐ No
 - If yes, what is the plan?
 - If no, who will assist with making plan?
 - Adult Education? ☐ Yes ☐ No

2. The youth has been diagnosed with the following disabilities: ☐ None

- | | | |
|---|---|--|
| <input type="checkbox"/> Mentally Impaired | <input type="checkbox"/> Specific Learning Disability | <input type="checkbox"/> Other Medically Diagnosed Condition |
| <input type="checkbox"/> Emotionally Impaired | <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Physically Disabled | <input type="checkbox"/> Speech and Language | <input type="checkbox"/> Not Yet Determined |

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3. Is the youth currently in special education? ☐ Yes ☐ No

- If yes, explain what services the youth will receive:

4. Does the youth have post secondary plans? ☐ Yes ☐ No

- If yes, where:

5. Has the following information been provided to the youth?

TIP	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ETV information	<input type="checkbox"/> Yes	<input type="checkbox"/> No
FAFSA information	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scholarship information	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date Provided

Date Completed

6. Does youth plan on attending trade school? ☐ Yes ☐ No

7. Who will be assisting the youth with post secondary planning?

Name and Title

Deadline

- ☐ DHS Staff:
- ☐ PAFC Staff:
- ☐ Foster Parents:
- ☐ Education Planner:
- ☐ High School Counselor:
- ☐ MYOI Staff:
- ☐ CASA:
- ☐ Supportive Adult:
- ☐ Other (explain):

Employment

1. Is the plan for the youth to be working? ☐ Full Time ☐ Part Time ☐ Contingent

2. Does the youth need to be referred to Michigan Rehabilitation Services? ☐ Yes ☐ No ☐ N/A

- If yes, when was he/she referred?
- If no, when will this be done and who will be assisting the youth or why N/A?

3. Is the youth currently working? ☐ Yes ☐ No

- If yes, please identify the employer's name and address:

- Is the youth working with a community resource/employment agency? ☐ Yes ☐ No

- If yes: ☐ WIA/Michigan Works! Agency
- If no, who will be making the referral for the youth to begin participating with an agency and by what date?

Name and Title

Deadline

- ☐ DHS Staff:
- ☐ PAFC Staff:
- ☐ Foster Parents:
- ☐ Employment Agency:
- ☐ AmeriCorp:
- ☐ MYOI Staff:
- ☐ Supportive Adult:
- ☐ Other (explain):

4. If the youth loses, quits, or gets fired from a job, what is the back-up plan?

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Transportation

1. What is the youth's plan for transportation?

- ☐ Public Transportation
☐ Bike
☐ Walking
☐ Other (explain):
☐ Has own vehicle
- Does the youth have car insurance? ☐ Yes ☐ No
 - If yes, what is the youth's source of funds for insurance? (family, friends, job, etc.)
 - If no, how with the youth get insurance and pay for it?
- ☐ Plans to purchase own vehicle
 - What is the plan to pay for ongoing maintenance?

2. Does the youth have a driver's license? ☐ Yes ☐ No
- If no, does the youth need driver's ☐ Yes ☐ No
 - If yes, what is the plan and date for enrolling and paying for driver's education?
 - Who will be assisting the youth with transportation needs?

Name and Title

Deadline

- ☐ DHS Staff:
☐ PAFC Staff:
☐ Foster Parents:
☐ Community Agency:
☐ Supportive Adult:
☐ Youth:
☐ Other (explain):

Michigan Youth Opportunities Initiative (MYOI)

1. Is the youth a participant in MYOI? ☐ Yes ☐ No ☐ N/A
- If no, was the MYOI referral made at the meeting or why N/A?

2. Has the youth participated in financial literacy ☐ Yes ☐ No ☐ N/A
- If no, how will he/she be provided with financial training or why N/A?

3. Does the youth have one or more of the following?

- ☐ Checking account ☐ Savings account ☐ Individual Development Account (IDA)

Finances

1. Upon transitioning out of care, what is the youth's plan to financially support

2. Has a credit check been completed on the youth in the last 12 months? ☐ Yes ☐ No
- If yes, what were the results?
 - If no, specify the plan for this to be completed prior to the youth's discharge:
 - Who, and by what date, will complete this?

3. For what services have applications been submitted? (check all that apply)

	<u>Submitted</u>	<u>Receiving</u>	<u>Monthly Amount</u>
<input type="checkbox"/> Cash Assistance/Family Independence Program (FIP)	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Child Day Care	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Employment	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Food Assistance Program (FAP)/Bridge Card	<input type="checkbox"/>	<input type="checkbox"/>	

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<input type="checkbox"/> Foster Care Transitional Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Independent Living Funds	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> RSDI/SSI	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Spousal Support/Child Support	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tribal Trust Funds	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Trust Funds	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other (please explain):	<input type="checkbox"/>	<input type="checkbox"/>	

4. Who will assist the youth with applying for these services?

	<u>Name and Title</u>	<u>Deadline</u>
<input type="checkbox"/>	DHS Staff:	
<input type="checkbox"/>	PAFC Staff:	
<input type="checkbox"/>	Foster Parents:	
<input type="checkbox"/>	Employment Agency:	
<input type="checkbox"/>	Supportive Adult:	
<input type="checkbox"/>	Other (explain):	

Health / Medication

1. Does the youth have a primary physician? ☐ Yes ☐ No
 - If yes, identify the physician's name and phone number:
 - If no, where will the youth access

2. Does youth have any ongoing medical needs? ☐ Yes ☐ No
 - If yes, identify all conditions/needs:

3. Does the youth have a durable Power of Attorney for Health Care? ☐ Yes ☐ No ☐ N/A

4. Current medications (list all and dosage):

5. Where does the youth get their

6. How will the youth pay for the prescription(s)? Source of

7. How does the youth plan on renewing the prescriptions?

8. Who, and by what date, will assist the youth with the above Health/Medication needs?

	<u>Name and Title</u>	<u>Deadline</u>
<input type="checkbox"/>	DHS Staff:	
<input type="checkbox"/>	PAFC Staff:	
<input type="checkbox"/>	Foster Parents:	
<input type="checkbox"/>	Employment Agency:	
<input type="checkbox"/>	MYOI Staff:	
<input type="checkbox"/>	Supportive Adult:	
<input type="checkbox"/>	Other (explain):	

Dentist's Name & Phone

Nearest Urgent Care or ER & Phone Number:

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Emotional / Mental Health

1. Has the youth stated a need for emotional support after transitioning? ☐ Yes ☐ No
- If yes, how will this be accomplished?

If the answer to #1 is no, skip to Substance Abuse Section.

2. Does the youth currently have emotional/mental health support? ☐ Yes ☐ No
- ☐ Community Mental Health
- ☐ Private/contracted counselor
- ☐ Clergy/Youth Pastor

If so, the youth will need to apply for FCTMA and locate a counselor or CMH.

3. Does the youth have a plan to meet his/her emotional/mental health needs? ☐ Yes ☐ No
- If yes, who will provide guidance and support?

Name and Title

Deadline

- ☐ DHS Staff:
- ☐ PAFC Staff:
- ☐ Foster Parents:
- ☐ Employment Agency:
- ☐ AmeriCorp:
- ☐ MYOI Staff:
- ☐ Supportive Adult:
- ☐ Other (explain):

Substance Abuse

1. Is substance abuse an identified need for the youth after he/she is discharged from foster care? ☐ Yes ☐ No
- If yes, are there identified funds to provide for services? ☐ Yes ☐ No
 - If no, what referrals have been made?

If the answer to #1 is no, skip to Social/Relational Section.

2. Is the youth receiving substance abuse counseling services? ☐ Yes ☐ No ☐ N/A
- If yes, identify the agency and counselor:
 - If no, specify the plan for the youth obtaining
 - Who will be assisting the youth?
3. Is the youth aware of substance abuse resources in the community where he/she will reside? ☐ Yes ☐ No ☐ N/A
- If no, specify the plan for the youth obtaining this information:
 - Who, and by what date, will be assisting the youth?

Social / Relational

1. Has the youth received information regarding Family Planning? ☐ Yes ☐ No
2. Has the youth received information regarding dating/domestic violence prevention? ☐ Yes ☐ No
3. Has the youth received information regarding lesbian, gay, bi-sexual, transgender, questioning (LGBTQ) issues? ☐ Yes ☐ No
4. Is the youth able to go to the church of his/her choice? ☐ Yes ☐ No
5. Is the youth aware of recreational facilities such as community centers, YMCA, YWCA, etc.? ☐ Yes ☐ No

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Parenting

1. Is the youth a teen parent, pregnant, or fathered any children? ☐ Yes ☐ No
- If yes, the number of children and their ages:
 - With whom are the children living? (Provide name and relationship to children)

If the answer to #1 is no, skip to Mentor/Supportive Adult Section.

2. Is child care needed? ☐ Yes ☐ No
- If yes, has a referral been made to the Child Care Coordinator: ☐ Yes ☐ No
 - Referral date and referral source:
 - If no, who is caring for the children?
3. Is CPS involved? ☐ Yes ☐ No ☐ N/A
- If yes, please identify the worker's name and phone number:
4. Is the youth, involved in a Teen Parenting Program? ☐ Yes ☐ No ☐ N/A
- If yes, please identify the agency:
 - If no, please identify available local programs:
 - Date of referral:

Mentor / Supportive Adult

1. Does the youth have an identified mentor? ☐ Yes ☐ No
- If no, has the youth requested a mentor? ☐ Yes ☐ No
 - Who, and by what date, will assist with identifying a mentor?
 - If yes, who is the mentor for the youth? (Identify by name and title and check all that apply)
 - ☐ Foster parent:
 - ☐ Supportive adult:
 - ☐ Teacher:
 - ☐ Foster Care Worker:
 - ☐ Relative:
 - ☐ Friend:
 - ☐ Other (explain):

Support System

1. For discharge in the next three months, who will the youth call for support?
- Name and Phone Number:
 - Name and Phone Number:
 - Name and Phone Number:
2. Does the youth have a plan in the event of an emergency? ☐ Yes ☐ No
- If no, who, and by what date, will be assisting the youth to develop an emergency plan?

Name and title

Deadline

- ☐ DHS Staff:
- ☐ PAFC Staff:
- ☐ Foster Parent:
- ☐ Supportive Adult:
- ☐ Mentor:
- ☐ School Counselor/School Support person:
- ☐ MYOI Staff:
- ☐ Other (explain):

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Discharge Documents

1. Which of the following required documents been provided to the youth? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Original Birth Certificate/Certified Copy
<input type="checkbox"/> State/Driver's Identification Card
<input type="checkbox"/> Psychological/Psychiatric Records
<input type="checkbox"/> Insurance Card (Medicaid)
<input type="checkbox"/> Tax Documents
<input type="checkbox"/> Placement history with permission of foster parents
<input type="checkbox"/> Copy of Plans (IL Agreement, etc.)
<input type="checkbox"/> Voter Registration Card (if 18+)
<input type="checkbox"/> Copy of 944/945 (Financial Aid Form) | <input type="checkbox"/> Legal Information
<input type="checkbox"/> Medical/Dental Records
<input type="checkbox"/> Financial Records (IDA, Banking, etc)
<input type="checkbox"/> Car Title
<input type="checkbox"/> FAFSA Brochure
<input type="checkbox"/> Selective Services Registration (Males)
<input type="checkbox"/> Publication 858
<input type="checkbox"/> Publication 161, Durable Power of Attorney | <input type="checkbox"/> Social Security Card
<input type="checkbox"/> School Identification Card
<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Family History/Life Book
<input type="checkbox"/> List of Resources
<input type="checkbox"/> Education Records
<input type="checkbox"/> Family Medical History |
|--|---|---|

2. How will DHS provide all of the documents to the youth prior to release?

Additional Needs (not covered in other areas)

Identified Needs Prior to Discharge

1.

2.

3.

Plan to address each identified need:

Signatures

Youth Name	Youth Signature	Date
DHS FC Caseworker or Monitor Name	DHS FC Caseworker or Monitor Signature	Date
PAFC Caseworker Name	PAFC Caseworker Signature	Date
Facilitator Name (if applicable)	Facilitator Signature (if applicable)	Date
Supervisor Name (if applicable)	Supervisor Signature (if applicable)	Date

Youth Confidentiality Statement

I understand that sensitive and confidential information regarding my case (including, but no limited to treatment and records of substance abuse, mental health and/or medical issues) may be discussed at this meeting for purposes of case planning. I give my permission for this information to be discussed and understand that I can revoke my consent to these discussions and/or request the exclusion of individuals from certain conversations or can end my participation in this meeting. I also understand, that any new information regarding possible allegations of child abuse or neglect must be reported to Child Protective Services.

Print Name	Signature	Date
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Team Member Confidentiality Statement

In accordance with the policies of Michigan Department of Human Services (DHS) and any applicable provisions of the Michigan law, I understand that as a member of this Family Team Meeting (FTM) I will have access to confidential information about an individual's or a family's involvement with DHS. I understand that my access to this information is limited strictly to the information necessary to carry out my role as part of the family team. I will not share information received at a team meeting concerning a youth or family member with anyone including other family members, friends of the family or professionals who are not a part of the FTM. Any new information regarding possible allegations of child abuse or neglect must be reported to Child Protective Services

Print Name	Signature	Role
Print Name	Signature	Role
Print Name	Signature	Role
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Print Name	Signature	Role
Print Name	Signature	Role

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.